

Public health competencies: prioritization and leadership

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Table 2 Strategic level and documentation required

Strategic level	Systematic documentation required
1. Situation analysis a. Population health b. Intervention systems 2. Selection of targets; identification of target groups 3. Selection of intervention 4. Implementation of intervention 5. Follow-up with evaluation of results of the concrete implementation as regards achievement of targets (→situation analysis)	Epidemiologic studies: surveillance Organizational studies: monitoring Balancing the result of the situation analysis and the choice of intervention Effect and cost-effectiveness studies Organizational studies; monitoring

Source: Birt and Foldspang² and Foldspang⁵.

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Public health competencies: prioritization and leadership

Since in his Viewpoint ‘10 years after: now from potential to action’, Anders Foldspang calls for ‘the continued discussion in the professional public health associations of European countries’, I would like to put forward a few considerations related to the European Public Health Core Competencies Project which include: (i) consensus, (ii) one size fits all, (iii) the need and (iv) public health leadership.

Consensus

Although the breadth and diversity of the public health workforce greatly contributes to the effective delivery of public health services, it also presents a formidable challenge for public health educators, leaders and public health workforce themselves, when it comes to state their identity. ASPHER’s European Public Health Core Competencies Project (EPHCCP) and its subsequent phases constitute the set of consensus-driven competencies which can be used for the development of academic degrees in public health. By identifying these core competencies, ASPHER aims to raise the bar for consistent quality of public health education providing the guidance to the Schools and Departments of Public Health (SDPH) on how to highlight the credibility of their degrees. Since, this product constitutes a point of reference for public health discipline and academic support in the strive for professionalization, the question arises whether we have done enough to make sure that the model provides a sufficient platform for engaging educators, students, public health employers, policy makers and other health professionals in discussion around the knowledge, skills and attitudes needed to protect and improve population health.

One size fits all

Competency sets generally have a limited lifespan. However, they are not developed in order to preserve a static educational framework—

rather, they are meant to be dynamic and stimulate the SDPH to adapt to meet the needs of evolving public health practice when faced with such challenges as: Ebola crisis, deepening health inequalities or climate change. Anders Foldspang states that ‘lists of competences must be updated to reflect developments in scientific public health evidence’, I would go even further by claiming that a continuous reassessment of competencies based on the reality check, developments in science and technology as well as crosscutting horizontal skills requirements relevant to local contexts and systems should drive a learning process that preserves valuable old skills, discards outdated ones, and adds new capabilities.¹ EPHCCP is an effort to develop a single universal competencies model. How to assure that the model represents one standard for all public health professionals in a diverse European region with varied burden of disease and the capacity of health systems?

The need

The scope of two ASPHER surveys directed to the SDPH in European Region² provided valuable insights into the state of the current public health education and training with the emerging trends and needs for strengthening the continuing education. Without a well-structured, integrative and comprehensive competency model, academic institutions involved in the professional development are challenged to ensure building the capacity and capability of public health workforce which is effective,

confident, competent and committed to protect and promote our health. However, the question arises whether the extensive list of ASPHER competencies can stimulate an equally constructive and focused discussion at all levels of professional development. In a genuine effort to exhaustively describe the discipline through the competencies, we may further complicate workforce development by creating robust lists of needed skills generally and within specific disciplines (e.g. epidemiology, or preparedness). Especially, if they are produced without clear prioritization and from which, it is difficult to discern or to look beyond discipline-specific needs and characteristics of public health workforce. This may lead to a critical gap in workforce development.

Prioritization

Current literature on the development of public health workforce provides many examples of competency priority areas. While Hunter states that informatics, community and multisector partnerships, and business-related analytics are currently underrepresented,³ other authors, claim that cutting across specific skill areas such as: management, leadership, politically savvy, innovativeness, adaptability and motivation are all in need of improvement.⁴ Further, the National Academy of Medicine identified eight emerging areas in need of competency development: informatics, communications, community-based participatory research, global health, ethics, genomics, cultural competency and policy and law.⁴ The Commission on the Education of Health Professionals for the 21st Century emphasized the importance of shared competencies, systems thinking, and social purpose together in a framework of instructional and institutional changes.¹

Faced with such developments, we can ask who should prioritize. Are these educators or mentors who support professional development of public health workforce? Or should we somehow highlight the priority competency areas while periodically updating the lists? Still, much more needs to be done to ensure that lifelong learning is a reality for public health professionals including a supportive training environment with access to quality, online learning resources.

Public health leadership

There is a strong realization of the vital role of leadership in public health. WHO mentions 'Strategic leadership for health' among the ten key areas of public health practice.⁵ Today, public health professionals require leadership skills including emotional skills and intercultural communication competencies, in order to lead effectively in multinational organizations. They need skills related to both transformational leadership serving a higher purpose and collaborative leadership sharing responsibility and accountability

with those who are involved in the decision-making and its outcomes. There now appears to be a developing consensus that public health organizations should build leadership capacity at every level. We should assure that the EPHCCP includes public health leadership competencies which can support the assessment and continuing professional development of public health workforce.

The ground work has been done by ASPHER. I would like to join Anders Foldspang in his call for action and discussion around the sustainability of the integrative competency model which meets public health workforce development needs, supports self-assessment and development of job descriptions. This seems to be the way not only to ensure that the public health workforce knows what to do to continuously improve but also to produce leaders who are motivated and capable to shape themselves and the future of public health.

Conflicts of interest: None declared.

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ISIS? Crop failure? And no antibiotics? What training will we need for the future of public health

Looking ahead, say, 25 years, what will be the public health problems our systems, our public health experts and practitioners will face? Will our skill set be different? In a world dominated by ISIS, crop failure and no antibiotics how will the people we train now, be acting effectively at the height of their careers?

My examples are for effect, but each may be a metaphor for areas of practice where we need to learn new skills, make new alliances and be more effective.

Isis

For *ISIS* read 'security'. We need to reclaim and revitalise our hold on the word 'security'. The 1994 Human Development Report extended 'security of territory' to 'freedom from danger' and 'freedom from want'.¹ Security in this context encompasses environmental security, welfare, social and health security, political as well as military security. In the era of crop failure and antimicrobial resistance we need to